Fee Basis Data: A Guide for Researchers

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Table of Contents

Acknowledgements

Glossary

AAC	Austin Automation Center
AWP	Average Wholesale Price
CALM	Centralized Accounting for Local Management
CDR	Cost Distribution Report
CMS	Center for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DHCP	Decentralized Hospital Computer Program
DSS	Decision Support System
E&M	Evaluation and management
FCDM	Financial and Clinical Data Mart
FMS	Financial Management System
ICD-9	International Classification of Disease, 9th Revision
IRMS	Information Resource Management Systems
MPCR	Monthly Program Cost Report
MST	Military Sexual Trauma
NDE	National Data Extract
NPCD	National Patient Care Database
OPC	Outpatient Care File
PTF	Patient Treatment File
RBRVS	Resource-Based Relative Value System
RVU	Relative Value Unit
VA	U.S. Department of Veterans Affairs
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISTA	Veterans Health Information Systems and Technology Architecture

Executive Summary

The Department of Veterans Affairs (VA) can make payments to non-VA health care providers under many arrangements. The most common are sharing agreements with affiliate medical schools and contracts with medical specialists. Non-VA care may also be authorized under the Fee Basis program. Originally established to enable veterans to obtain outpatient care near their homes, the program has expanded to cover the entire range of medical services. Fee Basis care is approved when VA treatment is not feasibly available.

Most Fee Basis services fall into one of five categories: short-term acute inpatient care, often followed by transfer to a VA facility; community nursing home care; emergency outpatient treatment; home-based care; and ongoing outpatient treatment in cases where the nearest VA facility is distant. Although Fee Basis payments represented about 4% of total VA health care spending in FY2003, they included a much larger fraction of payments for services often provided under contract, such as long-term care.

Each VA station tracks Fee Basis invoices and submits reports to the national office. These reports are merged to form a system-wide database consisting of eight files: four that record health care encounters and four for administrative and travel records. These files are available for research use by VA employees following a standard approval process. The Fee Basis data will be most useful for studying conditions where contract care is common, such as home-based care and nursing care, and for determining typical non-VA charges for health care services (both charges and payments are reported) and comparing those to VA costs.

This guidebook is intended to help researchers understand and use national Fee Basis files. It describes the contents of the files, notes their limitations, and offers suggestions for their use in research. It also provides information on file access and documentation, and contact information for Fee Basis managers.

I. Introduction

Federal law enables VA to pay for veterans' care at outside facilities when VA cannot offer needed care, when a non-VA provider would be economical, or on an emergency basis when travel to a VA facility is medically infeasible. In addition, VA may place a veteran in a private or state-run nursing home when a bed in a VA nursing home is unavailable or if the nursing home is distant from the patient's residence. Payment for these types of care falls under the Fee Basis program.

Fee Basis care represents a small fraction of all VA care for inpatient and outpatient services. As seen in the table below, payments for services rendered during FY2003 totaled just over $1.0 billion. Total VA spending for health care exceeded $23 billion in the same year. Nevertheless, Fee Basis data may report a large fraction of care for services typically provided on contract, such as community nursing home care.

Table 1. Fee Basis Utilization and Cost Summary: FY2003

Service type	Fee Basis Services	Total Payments
Inpatient*	116,000 stays	$ 545 million
Outpatient services (except pharmacy)	5,418,000 visits	$ 477 million
Outpatient pharmacy	15,000 prescriptions	$ 0.6 million
TOTAL		$ 1,023 million

* Includes long-term care and nursing home stays.

Fee Basis data from individual VA stations are collated to form national datasets. They feature information on patients, providers, care provided, charges and payments, and financial processing. The files are accessible to VA employees through timeshare accounts at the VA Austin Automation Center.

Relatively few published studies have made use of Fee Basis data. Chapko, Ehreth, and Hedrick (1991) discuss Fee Basis data in their early review of methods for determining the cost of VA health care. A large study of VA adult day health care (ADHC) programs counted contract care paid through Fee Basis and other programs (Chapko et al. 1993). Two studies have investigated the use of Fee Basis care by female veterans. Frayne et al. (2002) surveyed Women Veterans

Coordinators at VA facilities to determine how often Fee Basis care was used to provide low-volume services to female veterans. They found that most centers use Fee Basis care for procedures specific to females (e.g., mammography and gynecologic oncology), although very few used it for military sexual trauma counseling. Washington et al. (2003) assessed the availability of women's health services at VA facilities serving 400 or more women per year. Fee Basis and other contract care accounted for very small proportions of most services, except for serum pregnancy test (9.0% of 136 sites) and screening mammography (62.2%).

This report describes characteristics of Fee Basis data such as contents, missingness, and concordance between files, and makes recommendations about its use for research. The next chapter and Appendix 2 describe all variables in the FY2003 Fee Basis files, including variable name, type, length, and missingness. Chapter 3 describes how to access the data through the Austin Automation Center or the Financial and Clinical Data Mart. In Chapter 4 we present highlights of the outpatient data, focusing on the most common values of several important variables. Chapter 5 reports results of our analysis of overlap between the Fee Basis data and two other utilization data sources, the Non-VA Hospitalization File (part of the Patient Treatment File) and the Decision Support System (DSS) National Data Extracts for outpatient care. Chapter 6 offers detailed information about Fee Basis eligibility and payment rules, information critical to understanding utilization and cost patterns in the data. In Chapter 7 we summarize our notes and recommendations for researchers. Chapter 8 provides contact information for individuals knowledgeable about the Fee Basis program and data.

II. Data

File names

There are eight Fee Basis files for each fiscal year. Table 2 lists their Austin Automation Center (AAC) file names and gives a general description of their contents. The files are stored in SAS[®] data file format.

Table 2. AAC File Names and Brief Descriptions

Type of Data	Name Suffix	Full AAC File Name[1]
Hospital stays	INPT	MDPPRD.MDP.SAS.FEN.FYyy.INPT
Inpatient ancillary services and physician charges	ANIP	MDPPRD.MDP.SAS.FEN.FYyy.INPT.ANIP
Outpatient services	MED	MDPPRD.MDP.SAS.FEN.FYyy.MED
Payments to pharmacies	PHR	MDPPRD.MDP.SAS.FEN.FYyy.PHR
Travel expenses	TVL	MDPPRD.MDP.SAS.FEN.FYyy.TVL
Pharmacy vendors	PHARVEN	MDPPRD.MDP.SAS.FEN.FYyy.PHARVEN
All other vendors	VEN	MDPPRD.MDP.SAS.FEN.FYyy.VEN
Veterans receiving long-term Fee Basis care	VET	MDPPRD.MDP.SAS.FEN.FYyy.VET

[1]Substitute the last two digits of the fiscal year for 'yy' in the file names above.

File Contents

Care provided through the Fee Basis program is entered by VA staff into the VISTA Fee Basis package. Data entries are based on invoices submitted to VA, at times supplemented by information gathered during telephone calls to the non-VA providers. Extracts from local VISTA systems are merged to form national Fee Basis data files. (Appendix 1 contains a more detailed description of the processing of Fee data.)

About 120 variables appear in one or more of the seven Fee Basis files. Table 5 – placed at the end of this chapter due to its length – lists each variable and indicates with an 'X' which files the variable appears in.   In some cases there are two or more variables representing the same concept. For example, fiscal year appears as "FISYR" in three files and "FY" in two others.

An official data dictionary has not been created for the Fee Basis files. We therefore used the SAS procedure PROC CONTENTS to generate a list of all variables. Results appear in Appendices 2.1-2.8, where each appendix pertains to a separate Fee Basis file. For each variable we report the name, type (numeric or character), length, format, and label. We also report its rate of missingness, generated from a different SAS procedure. FY2003 Fee Basis files were nearly identical to those of FY2004 and so are not reported separately.

In the inpatient stay (INPT) file, a record represents services rendered during one invoice period. Hospitals often invoice VA once per calendar month, and so a stay that covers parts of two calendar months will typically be represented by two (or more) invoices. In the inpatient ancillary (ANIP) and outpatient services (MED) files, each record shows a single Current Procedure Terminology (CPT) code per record representing a single procedure or encounter. Some encounters have multiple procedures that are paid as a single encounter; other encounters have multiple procedures and there are separate payments for each procedure..

A single inpatient encounter may generate zero, one, or multiple ANIP records, depending on the number of ancillary procedures and physician services received. Each record in the pharmacy services (PHR) file represents a single prescription, whether for a medication or a pharmacy supply (e.g., skin cleanser, bathing cloths). Each record in the vendor files (PHARVEN, VEN) pertains to a particular vendor, while Fee ID (VET) records correspond to individual veterans rather than the particular services those veterans have received.

Below we summarize the contents for six categories of variables: patient demographics, military service, location, clinical aspects, payment, and financial processing within VA.

Demographic variables
The demographic information in the Fee Basis files is limited to patient gender (SEX) and date of death (DEATHDT), if any, in the VET file. Because the VET file contains relatively few records, researchers must match Fee Basis records to other VA databases, such as the Outpatient Care File (OPC/NPCD), the Patient Treatment File (PTF), of the Decision Support Systems

(DSS) National Data Extracts to obtain demographic data. The Fee Basis files have a patient ID variable (scrambled SSN [SCRSSN]) that enable researchers to merge these data.

Military service variables

Variables representing period of service (WARCODE) and prisoner-of-war status (POW) appear in the VET file. No other service-related variables appear in the Fee Basis files. Service variables for all Fee Basis patients can be obtained from other VA databases.

Location variables

Every Fee Basis file contains variables for parent station,[1] county of residence, and state of residence (including Canadian provinces and certain foreign countries). Table 3 lists the variable names and formats.

We checked the concordance of corresponding numeric and character values across records. Numeric values were associated with the same character values consistently, except when HOMSTATE took the values of '90' or '99.' Potential errors in HOMSTATE appear in HOMECNTY as well, which is derived by concatenating HOMSTATE and CNTY. Finally, note that primary service area (HOMEPSA), which designates the VA medical center responsible for inputting the Fee Basis record into VISTA, is not always equivalent to STA3N.

Table 3. Names and formats of location variables

Variable	Numeric Format	Character Format
VA Station	STA3N (3 digits)	STA6A (6 digits)
County	CNTY HOMECNTY	*None*
State[1]	HOMSTATE	STATE

[1]Includes Canadian provinces, Puerto Rico, Guam, and the Phillippines

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[1] Parent station is intended to reflect the VA station the patient is most likely to use.

Clinical variables

Table 4 lists the clinical variables available in Fee Basis files. There are up to five ICD-9 diagnosis codes recorded in the inpatient discharge (INPT) file and one in the outpatient services (MED) file. There are no diagnosis codes in the ancillary and physician services (ANIP) file, although these records can be linked by patient ID and service dates to discharge records in the INPT file. Diagnosis codes do not appear on the pharmacy (PHR) file. Each ancillary (ANIP) and outpatient (MED) record contains a single CPT procedure code. The inpatient discharge (INPT) file contains up to five ICD-9 surgery codes. In FY2004 they were blank more than 75% of the time, indicating that most patients did not receive emergency surgery during the stay. Elective and non-emergent surgeries are not covered by the Fee Basis program.

Table 4. Clinical and Related Variables in FY2003 Encounter-Level Files

Variable	Variable Name	Inpatient Facility (INPT)	Inpatient Ancillary (ANIP)	Outpatient (MED)	Pharmacy (PHR)
Diagnoses (# codes)	DXLSF, DX2-DX5	5	0	1	0
Surgeries (# codes)	SURG9CD1-SURG9CD5	5	0	0	0
Procedures (# codes)	CPT1	1*	1	1	0
Vendor Type	TYPE	Yes	Yes	Yes	Yes
Payment Category	PAYCAT	Yes	Yes**	Yes	Yes
Fee Purpose of Visit	FPOV	Yes	Yes	Yes	No
HCFA Payment Type	HCFATYPE	No	Yes	Yes	No
Treatment Code	TRETYPE	No	No	Yes	No
Place of Service	PLSER	No	Yes	Yes	No

* All values were missing in FY2004.
** All values were missing in FY2004 but not in FY2003.

Six additional variables offer limited clinical or procedure information. Formatted values appear in Appendix 3. Vendor type (TYPE), payment category (PAYCAT), treatment code (TRETYPE), and place of service (PLSER) all provide information on the type or setting of care. They could form part of an overall strategy to locate care provided in specialized settings, such as state homes, or of specialized services like kidney dialysis. The Fee Purpose of Visit (FPOV) and Health Care Financing Agency Payment Type (HCFATYPE) variables feature values

pertaining to setting (inpatient, outpatient, home-based), specific items (e.g., supplies and diagnostics), and miscellaneous purposes.[2]

<u>Payment variables</u>

The Fee Basis files' primary purpose is to record VA payments to non-VA providers. Several variables indicate the amounts claimed and paid. PAMTCL, the claimed amount (charge), appears in the inpatient (INPT) file alone. Claimed amounts should be listed on all invoices submitted to VA, but except for inpatient facility claims they are not added to the Fee Basis files. It may be possible to extract charges from the VISTA system of a particular medical center.

The amount paid to vendors is expressed in two variables, AMOUNT and DISAMT. AMOUNT has a decimal point whereas DISAMT does not. Thus, DISAMT $\div$ 100 = AMOUNT. The number of nonmissing values differs slightly between them. In the FY2004 inpatient (INPT) file, for example, there are 115,718 nonmissing values of AMOUNT and 115,336 nonmissing values of DISAMT, a difference of 372 (0.3%).

The interest paid on the claim is represented by the variable INTAMT. It has two implied decimal places. For example, an interest payment of $14.21 would appear as '1421'. INTAMT is part of AMOUNT and DISAMT; it should not be added to them.

The inpatient (INPT) file includes PAMT, the Medicare prospective payment that would apply to the stay. VA calculates PAMT from CMS pricer software on the basis of DRG and length of stay. There are additional payment for direct medical education, capital-related costs, and other factors as appropriate. The VA payment (DISAMT) is typically less than or equal to the PAMT value, although in some cases VA will pay more than Medicare would pay. For more details, including rules for handling patients transferred during a stay, see 38 CFR 17.55.

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[2] The Health Care Financing Administration (HCFA) has been renamed the Centers for Medicare and Medicaid Services (CMS).

The pharmacy vendors (PHARVEN) and all other vendors (VEN) files contain only summary payments by month. These data records cannot be linked to particular patients or encounters. Likewise, the Fee Card (VET) file contains only summary payment figures by month, although researchers can match the records to other data by SCRSSN and other identifiers.

The travel payments (TVL) file shows reimbursements for particular travel events, TVLAMT. Through patient ID (SSN or SCRSSN) and travel date (TVLDTE) one can link these payments to encounters recorded in the encounter-level inpatient and outpatient files (INPT, ANIP, MED).

Financial processing variables

Many variables in the Fee Basis files record details of invoice and check processing. Most files contain the invoice date, obligation number, check number and date, several variables pertaining to check cancellation and denials of payment, and the DHCP internal control number. Five additional variables – Financial Management System (FMS) transaction number, line number, date, batch number, and release date to Centralized Accounting for Local Management (CALM)– reflect processing of payments through the FMS. CALM was the predecessor of FMS and should be treated as synonymous with it. These variables will be of little interest to researchers, and so they will not be described further in this report.

Missingness

The last column of Appendices 1.1 – 1.7 show the percentage of variable values missing in the FY2004 files. Missingness in FY2003 files was quite similar for most variables. Rates of missingness are generally low, with these exceptions:

- MDCAREID: Medicare Provider ID (INPT, ANIP files) – 99-100% missing[3]
- CPT1: outpatient procedure code (INPT file) – 100% missing
- PAYCAT: payment category (ANIP file) – 100% missing in FY2004
- Several FMS processing variables (all files) – 98-100% missing

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[3] This does not imply that the Medicare provider ID is unknown to VA, but that the variable is not being populated with the ID value.

- VENDID and CHAINNUM: pharmacy vendor ID and vendor chain number (PHR file) – 33% missing in FY03, 26% missing in FY2004
- SPECCODE: suspense code (VEN, PHARMVEN) – 57-60% missing in VEN, 100% missing in PHARMVEN

The impact of these missing values will be small in many cases. Inpatient procedures are captured by ICD-9 codes (SURG9CD1-SURG9CD5), whereas the CPT1 code is typically used for outpatient procedures. The CPT1 variable in the inpatient (INPT) file appears to serve merely as a placeholder. The FMS processing variables and the suspense code (SPECCODE or SUSCODE), whose 18 values refer to invoice processing or claim type, are unlikely to be used for research.

The Medicare provider ID (MDCAREID) is required by Medicare Pricer software to determine the prospective payment for a stay. The prospective payment already appears in the variable PAMT, however, and thus the provider ID may be unneeded. An alternative approach is to use the vendor identification variables (VEN13N, VENDID) to locate the vendor's name and location in the VEN file, and then to use this information to find the Medicare provider ID using publicly available files from CMS, the agency that oversees the Medicare program.

The payment category (PAYCAT) is entirely missing in the inpatient services (ANIP) file in FY2004, although almost no values were missing in FY2003. The PAYCAT value could be determined by finding the matching inpatient stay in the INPT file. Only 2.2% of PAYCAT values in the INPT file were missing in FY2004, and none were missing in FY2003.

Researchers must consider whether a missing value means "not applicable." For example, the high rates of missingness among inpatient surgery codes (SURG9CD1-SURG9CD5) most likely reflect a low frequency of surgery. The Fee Basis program will not pay for non-emergent surgery, and thus we should expect to see relatively few of them in these data. Conversely, all stays should have at least one discharge diagnosis. The missing values of the primary diagnosis code (DXLSF) should be therefore be treated as truly missing. The same cannot be said for DX2-DX5, however, as additional diagnosis codes are optional.

Notes and Recommendations

- The same concept (such as fiscal year, state, or county) may be represented by several variables, sometimes in differing formats.

- Missingness can vary substantially by year, by file, and by variable.

Table 5. Names and File Locations of All Fee Basis Variables, FY2004

Variable	Fee Basis File							
	INPT	ANIP	MED	PHR	PHARVEN	VEN	VET	TVL
ACTCODE	X	X	X	X			X	
ADHCP		X						
AGECNTL								X
AMOUNT	X	X	X	X				
AMTCLMD				X				
APRMOTR					X	X		X
AUGMOTR					X	X		X
BATCHNUM	X	X	X	X			X	
CANCODE	X	X	X	X			X	
CANDAT	X	X	X	X			X	
CANRSN	X	X	X	X			X	
CCADDR1								X
CCADDR2								X
CCCITY								X
CCCNTY								X
CCCODE								X
CCST								X
CCZIP								X
CHAINNUM				X			X	
CHKDAT	X	X	X	X			X	
CLMDATE	X	X	X	X			X	
CNTY	X	X	X	X				X
CPT1	X	X	X					
DEATHDT								X
DECMOTR					X	X		X
DELCODE								X
DHCP	X		X	X			X	
DISAMT	X	X	X	X			X	
DOB								X
DX2	X							
DX3	X							
DX4	X							
DX5	X							
DXLSF	X		X					
EFTNO	X	X	X	X			X	
ENDDTE								X
FEBMOTR					X	X		X
FILLDTE				X				
FISYR	X	X	X					

Table 5. Names and File Locations of All Fee Basis Variables (cont'd)

Variable	Fee Basis File							
	INPT	ANIP	MED	PHR	PHARVEN	VEN	VET	TVL
FMSTNO	X	X	X	X			X	
FPOV	X	X	X					X
FY				X			X	
HCFATYPE		X	X					
HOMECNTY	X	X	X	X	X	X		X
HOMEPSA	X	X	X	X				
HOMSTATE	X	X	X	X	X	X		X
INTAMT	X	X	X	X			X	
INTIND	X	X	X	X			X	
INVDATE	X	X	X	X				
INVLNNUM	X	X	X	X			X	
INVNUM	X	X	X	X			X	
ISSUEDT								X
JANMOTR					X	X		X
JULDAY	X	X	X	X			X	
JULMOTR					X	X		X
JUNMOTR					X	X		X
LASTPAY								X
LINENO	X	X	X	X			X	
LPAYTYP								X
MARMOTR					X	X		X
MAYMOTR					X	X		X
MDCAREID	X	X						
NOVMOTR					X	X		X
OBNUM	X	X	X	X			X	
OCTMOTR					X	X		X
PAMT	X							
PAMTCL	X							
PARTCODE					X	X		
PATTYPE	X	X	X					
PAYCAT	X	X	X	X			X	
PAYTYPE	X	X	X	X			X	
PDRG	X							
PLSER		X	X					
POW								X
PRESC				X				
PROCDTE	X	X	X	X			X	
RELNO	X	X	X	X			X	
SCRSSN	X	X	X	X			X	X

Table 5. Names and File Locations of All Fee Basis Variables (cont'd)

Variable	Fee Basis File							
	INPT	ANIP	MED	PHR	PHARVEN	VEN	VET	TVL
SEPMOTR					X	X		X
SEX								X
SPECCODE					X	X		
SSNSUF	X	X	X	X			X	X
STA3N	X	X	X	X	X	X	X	X
STA6A	X	X	X	X	X	X	X	X
STANUM	X	X	X	X			X	
STASUF								X
STATE	X	X	X	X				
STRTDTE								X
SUFNAM								X
SURG9CD1	X							
SURG9CD2	X							
SURG9CD3	X							
SURG9CD4	X							
SURG9CD5	X							
SUSCODE	X	X	X					
TRANSDAT	X	X	X	X			X	
TREATDT			X					
TREATDTF	X	X						
TREATDTO	X	X						
TRETYPE			X					X
TVLAMT							X	
TVLDTE							X	
TYPE	X	X	X	X	X	X	X	X
VALENDY								X
VATYPE			X					
VEN13N	X	X	X	X	X	X	X	
VENDID	X	X	X	X	X	X	X	
VENNAME					X	X		
VENSITEN	X	X	X	X			X	
VENSUF	X	X	X		X	X		
VINVDATE	X	X	X	X			X	
VTADDR1								X
VTADDR2								X
VTADDR3								X
VTCITY								X
VTICN								X
VZIP					X	X		

Table 5. Names and File Locations of All Fee Basis Variables (cont'd)

Variable	Fee Basis File							
	INPT	ANIP	MED	PHR	PHARVEN	VEN	VET	TVL
WARCODE								X
XSEX								X
ZIP	X	X	X	X				X

III. Access

There are two ways to access Fee Basis data. The raw files are stored at the Austin Automation Center and are accessed through timeshare accounts. Summary data are also available through the Financial and Clinical Data Mart, a web-based application.

Austin Automation Center

VA users may obtain Austin Automation Center (AAC) timeshare accounts through their local Information Resource Management Systems (IRMS) office. The request must specify the functional task code that corresponds to Fee Basis data. The code is confidential and may be obtained through IRMS or by request to HERC. Once access to AAC is obtained, the Fee Basis files may be manipulated and extracted through SAS programs.

Financial and Clinical Data Mart

Summary Fee Basis expenditure data for FY2002-FY2004 are also available within the Financial and Clinical Data Mart (FCDM). The data may be accessed through the "KLFMenu" (http://klfmenu.med.va.gov), the website of the VA VISN Support Services Center. The KLFMenu is accessible only to users having access to the VA intranet.

To access the FCDM, follow these steps using a Microsoft Internet Explorer browser:
1. Log into the KLFMenu
2. On the left, click on the "Financial and Clinical Data Mart (FCDM)"
3. Click on "VHA FCMD Cubes on Proclarity Analytic Server"
4. Log into the Proclarity server using *domain/username* (e.g., vha02/vhawnyjones) and one's VA network password
5. Click on "K. Non VA Care"
6. Click on "1. Non-VA Care Review"
7. Click on "Reports"

Sixteen reports were available as of early September, 2005. Their titles are listed in Table 6. All report payments (disbursed amounts) by VISN or station within a particular fiscal year. Some provide additional details, such as counts of unique patients or additional clinical detail. To learn

the meaning of payment and utilization variables in these tables, return to Step 6 above. Instead of clicking on "Report," click on "Data Definitions and Documentation."

Table 6. Fee Basis Reports on KLFMenu (Sept. 14, 2005)

Top 20 Vendors by Disbursed Amt
Top 20 Inpatient Contract Hospital DRGs by Disbursed Amount
Top 20 CPT Codes by Disbursed Amt
Top 20 ICD9 Codes by Disbursed Amount
Purpose of Visit by Year for selected location
Place of Care Measures (Fee Inpatient/Outpatient Only)
Community NH Costs by VISN (Inpt and Inpt Ancillary)
County and Fee Purpose of Visit (Ancillary/Other/Inpt/Outpt) Disbursed Amount
Place of Care Measures (Fee Inpatient/Outpatient/Ancillary/Pharmacy)
Inpatient Ancillary Costs by VISN
Disbursed Amt for FY04 (Location by FPOV Group)
Disbursed Amt By VISN by Transaction Year
Analysis for General Fee Info
Non VA Care for NSC[1]
Obligation/disbursed amount
Obligation by Purpose of Visit

[1]NSC = non-service-connected veteran

The data cubes contain only summary information. They cannot be used to obtain data on specific individuals or encounters.

IV. Outpatient Utilization and Cost Figures

To illustrate both benefits and drawbacks of the Fee Basis data, we investigated the types of services found in outpatient (MED) files. By combining large numbers of observations, one can quickly determine average payments for a wide range of outpatient procedures. Coding of setting and treatment type appears to be uneven across variables, however, suggesting caution in the use of Fee Basis data for locating all instances of a particular form of care.

The 20 most common CPT procedure codes in FY2003 are listed in Table 7. Home health care services were responsible for eight of the twenty (nos. 1-4, 6, 8, 10, and 17). Together they accounted for approximately 1.5 million visits in FY2003. Kidney dialysis and related services appear four times (nos. 7, 11, 12, and 14) and accounted for 275,000 services. The remaining codes pertain to a variety of other services. The last code listed, J2501, was labeled "UNKNOWN" but represents an injection of paricalcitol.

Although evaluation and management (E&M) codes are common in VA, only one code among the top 20 pertained to E&M. This might occur because patients may use non-VA providers for procedures rather than for management of chronic illnesses, or providers may use alternative CPT codes in order to maximize payments.

Table 8 shows all values of the Fee Purpose of Visit (FPOV) codes that appear in FY2003, sorted by frequency. It also shows the average payment for services within each code. A total of 34 codes were used. A majority of records, about 2.75 million, are coded with clinically uninformative values pertaining to service connection status or payment authority. Ten more pertain to dental care. The remaining codes include a variety of purposes, such as compensation

A comparison of the table with FY2004 FPOV values reveals that the values vary by year. "Home-based care," for example, is represented by '71' in FY2003 and '42' in FY2004. When looking across years for a particular FPOV type, one must begin by printing out all formatted values of FPOV for each year to determine which value (number) represents which type of care each year.

Table 7. Top 20 CPT Procedure Codes and Average Payments, FY2003 Visits, MED File[1]

Rank	CPT	Label	Frequency	Average Payment
1	G0156	SERV HOME HLTH AIDE / HOME / EA 15 MIN	544,437	$47.44
2	G0154	SERV SKL NURS / HOME HLTH SET / 15 MIN	301,713	$82.01
3	S9122	HOME HEALTH AIDE / CAN CARE / HOME / HOUR	179,749	$50.61
4	99347	HOME VISIT E&M ESTAB PT MINOR PROB - 15 MI	167,396	$47.63
5	97110	THERAP PROC 1/> AREAS EA 15 MIN; EXERCIS	124,713	$36.73
6	99349	HOME VISIT E&M ESTAB PT MOD-HI SEVERITY-	112,598	$64.42
7	90937	HEMODIALYSIS PROC W/ REPEAT EVAL W/WO REV	91,916	$149.72
8	99350	HOME VISIT E&M ESTAB PT MOD-HI/ UNSTABLE-	82,337	$48.53
9	90806	PSYCHOTX OV/OP BEHV MOD/SUPPT 45-50 MIN;	71,879	$84.41
10	99348	HOME VISIT E&M ESTAB PT LOW-MOD SEVERITY	70,266	$54.59
11	90935	HEMODIALYSIS PROC W/ SINGLE PHYSICIAN EVA	65,120	$168.65
12	90999	UNLISTED DIALYSIS PROCEDURE INPATIENT/OU	62,460	$187.03
13	99070	SPL/MATL PROV-PHYS NOT INCL W/VISIT/ OTHR	59,852	$127.97
14	A4657	SYRINGE WITH OR WITHOUT NEEDLE FOR DIALY	59,165	$5.31
15	99213	OFC/OUTPT VISIT E&M EST LOW-MOD SEVERITY	53,887	$50.47
16	99499	UNLISTED EVALUATION AND MANAGEMENT SERVI	52,103	$50.37
17	99509	HOM VISIT ASSTANCE W/ACTV DAILY LIVING&P	45,402	$51.87
18	77413	RADIATION TX DELIV-3/MORE TX AREAS; 6-10	45,273	$121.16
19	36415	ROUTINE VENIPUNCT / FNGR / HEEL / EAR STICK CL	44,790	$8.28
20	J2501	UNKNOWN *(1mcg Paricalcitol Injection)*	44,712	$71.86

[1] FY2003 and FY2004 data were combined to create a broader set of Fee Basis visits occurring during FY2003.

Table 8. Fee Purpose of Visit (FPOV) Codes in Outpatient Services (MED) File with Average Payment Amount, FY2003[1]

FPOV Value	Label	Frequency	Average Payment
	Eligibility Status		
5	OPT FOR NSC	1,333,143	$127.61
10	OPT > OR =50% SC	1,201,850	$89.00
9	OPT < 50% SC	456,087	$105.54
52	OPT 38 U.S.C. 1725	254,924	$55.75
11	OBVIATE NEED	82,526	$126.60
2	OPT UNAUTH CLAIM	93,202	$73.71
6	AA/HB BENEFITS	37,285	$69.61
8	OPT WWI MEX BOR	177	$31.27
	Home Health Care		
71	HOME HEALTH	831,804	$51.72
70	HOME HEALTH NURS	790,179	$69.54
74	HHS (NON-NURSE PROF)	124,987	$41.19
72	RESPITE CARE IN HOME/HOME HAS	1,117	$48.26
82	FEE OXYGEN	28	$15.62
	Dental Care		
22	CLASS IV DENTAL	41,670	$191.17
24	CLASS VI DENTAL	1,877	$162.07
19	CLASS IIC DENTAL	1,785	$153.90
23	CLASS V DENTAL	1,283	$169.78
16	CLASS II DENTAL	1,278	$233.05
15	CLASS I DENTAL	1,032	$229.02
21	CLASS III DENTAL	1,005	$177.30
17	CLASS IIA DENTAL	466	$228.72
20	CLASS IIR DENTAL	136	$32.61
18	CLASS IIB DENTAL	56	$110.39

table continues on next page

Table 8, continued

FPOV Value	Label	Frequency (2 Years)	Average Payment
	Other Codes		
1	COMP AND PEN	59,141	$121.06
7	MISCELLANEOUS	39,333	$84.48
76	ADULT DAY HEALTH CARE (ADHC)	26,318	$75.92
78	OPT HOSPICE CONT	25,799	$124.01
3	APP-MED BENEFIT	22,501	$202.60
77	OPT HOSPICE FEE	7,051	$180.55
75	CHIROPRACTIC CARE	6,033	$30.58
73	RESPITE CARE IN ADHC	1,647	$100.62
79	RESPITE CARE OTHER	335	$45.35
55	MST	315	$77.24
4	VA INSURANCE	283	$176.75

[1] This table represents stays that occurred during FY2003. Because the Fee Basis data are grouped by invoice date rather than service date, we combined data from FY2003 and FY2004 files to determine a reasonably complete set of FY2003 services. Note that some FPOV codes changed from FY2003 to FY2004. The FY2003 values appear above, while FY2004 values appear in Appendix 3.

and pension exams used to determine service connection (COMP AND PEN), military sexual trauma (MST), and chiropractic care.

Table 9 presents the frequency of HCFA Service Type (HCFATYPE) incurred in FY2003 visits recorded in the MED file, and the average payment for each. A majority of observations falls under two uninformative codes, "medical care" and "other medical service." The values have moderate specificity in some cases, such as anesthesia, pneumococcal vacination, blood/packed cells, and radiation therapy. Letter values (C, D, F, G) had no assigned formats, and thus their meanings are unknown.

There is no strict relation between HCFATYPE and FPOV. For example, the number of hospice values reported through HCFATYPE in Table 9 (15,762) is significantly less than the total number by FPOV in Table 8 (25,799 + 7,051). To find all outpatient hospice care, the best approach is to use the union of those two sets of observations rather than their intersection.

Table 9. HCFA Type of Service (HCFATYPE) Codes in Outpatient Services (MED) File with Average Payment Amount, FY2003 Visits[1]

Value	Meaning	Frequency	Average Payment
1	MEDICAL CARE	3,178,329	$86.91
9	OTHER MED SER	1,174,140	$73.04
[blank]	UNKNOWN	239,120	$107.22
5	DIAG LAB	234,719	$36.69
4	DIAG XRAY	177,606	$157.15
6	RADIATION THERAP	173,469	$170.84
2	SURGERY	73,836	$278.19
3	CONSULTATION	58,734	$97.73
M	ALT PAY MN DIAL	54,014	$93.68
Y	2ND OP ELEC SURG	29,351	$70.37
H	HOSPICE	15,762	$116.02
N	KIDNEY DONOR	14,496	$81.65
43	DIAG XRAY PROF C	9,340	$53.72
7	ANESTHESIA	6,242	$423.58
V	PNEUMOCCAL VACC	2,445	$78.71
53	DIAG LAB PROF CO	1,412	$29.99
Z	3RD OP ELEC SURG	1,094	$111.41
0	BLD/PACKED CELLS	880	$81.32
8	ASSIST SURG	807	$47.21
F	F *(no format assigned)*	557	$410.96
A	USED DME	144	$107.45
L	RENTAL SUPP HOME	135	$153.77
D	D *(no format assigned)*	15	$56.34
C	C *(no format assigned)*	5	56.34
G	G *(no format assigned)*	1	70.00

[1] FY2003 and FY2004 data were combined to determine a more complete set of Fee Basis visits occurring during FY2003.

Notes and Recommendations

- Watch for outlier values. One method for replacing an apparent outlier is to use the average value of payments for the same CPT in the same year, if possible to the same provider.

- VA will pay invoices as late as two years after the service was rendered. One must therefore look across three years of Fee Basis records to find all costs for a particular fiscal year. In practice, all invoices for most encounters are paid within six months. The average payment lag is 4-5 months – longer than in private sector.

- To identify care at a particular location or of a particular type, search using all relevant variables. For example, place of service (PLSER), treatment code (TRETYPE), and purpose of visit (FPOV) can all available in the outpatient (MED) file.

- Investigate whether variables give contradictory information on place of service or service type. There is no widely accepted standard for determining how much agreement across variables is sufficient.

V. Overlap with Other VA Data Files

Overview

VA contracts with outside providers through several arrangements beyond the Fee Basis program, such as sharing agreements with affiliate medical schools and contracts with medical specialty groups. Spending on the Fee Basis program therefore represents only a portion of total VA expenditures for contract care. Total contract care spending was reported by fiscal year in the Cost Distribution Report (CDR). The final year of the CDR was FY2004; its successor, the Monthly Program Cost Report, lists contract costs for each VA medical center.

The Fee Basis system is the only method for reporting payments to non-VA providers for care at non-VA facilities. We therefore expect little overlap between Fee Basis data and records in other VA databases. VA funds distributed through the VERA system depend on workload, however, and so there is a natural incentive to capture as much workload as possible.

There are two significant instances in which Fee Basis data are transmitted to other utilization data files: nursing home care and completed inpatient stays.   Nearly all community nursing home care is also reported in the DSS NDE for outpatient care.[4] It appears in the outpatient file instead of the inpatient file so that interim workload may be reported before the patient is discharged. A single service date is recorded for the invoice rather than the invoice period. A completed inpatient hospital stay may appear in two VHA files. The Health Information Management Section at each medical center enters information on non-VA inpatient stays into VISTA. The data later become part of the Non-VA Hospitalization (NVH) file within the Patient Treatment File (PTF) as well. This enables the medical center to obtain credit for workload, which in turn affects medical center payments through the Veterans Equitable Resource Allocation (VERA) system. The data enter NVH only after a discharge occurs.

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[4] Personal communication, Steven Porter (HAC DSS office), 2005.

Comparing Fee Basis and Non-VA Hospitalization Records

Notes from national Fee Basis conference calls indicate that some non-VA discharges do not make it into the NVH files. We therefore compared the contents of the two files for FY2003 to determine the proportion of completed stays that were entered into the NVH.

NVH is a file of completed stays, and so we created a temporary file of completed stays using the invoice-level records in the Fee Basis INPT file. Using patient ID, vendor ID, and invoice start and end dates as matching variables, we concatenated individual claims into chains having no break of one day or more.[5] The first day (TREATDTF) of the first invoice in the chain was considered to be the admission date, and the last day (TREATDTO) of the last invoice in the chain was considered to be the discharge date. We eliminated stays whose last day was September 30, 2003, the last day of FY2003, because many of these will have continued into FY2004. This yielded a total of 50,268 stays that finished during FY2003. We will refer to them as the *New Fee Basis Discharge File*.

Table 10. Number of Stays among Inpatient Users in the FY2003 INPT and PTF Non-VA Hospitalization Files

No. of Stays per User	New Fee Basis Discharge File		PTF Non-VA Hospitalization	
	Frequency	**Percent**	**Frequency**	**Percent**
1	41,299	82.2	16,043	86.8
2	6,497	12.9	1,778	9.6
3	1,606	3.2	460	2.5
4	509	1.0	130	0.7
5 or more	357	0.7	82	0.4
TOTAL	50,268	100.0	18,493	100.0

Note: Percentages may not add to 100% due to rounding.

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[5] For example, suppose that an invoice period (TREATDTF to TREATDTO) ended on January 12. If the period of the next invoice began on January 12 or January 13, then the two were considered parts of a single stay. Otherwise they were considered parts of distinct stays.

Table 10 shows the distribution of the count of stays among users, those having any stays. More than 82 percent of stays lasted only a single day, and 95 percent lasted no more than two days. These brief stays suggest either that many are observation stays that did not require additional inpatient treatment, or that many patients transferred quickly to VA facilities.

The total number of stays varied considerably by source. Some types of Fee Basis stays do not enter the PTF NVH files, such as community nursing home and state home stays. As well, some VA sites appear not to create NVH records for every qualified stay in the Fee Basis data.

Length of stay (LOS) is a common outcome of health services studies. We therefore investigated whether LOS for matched stays in Fee Basis and NVH files were similar. For our Fee Basis discharge file we defined length of stay by the formula *LOS = max (1, (discharge date – admission date)),* where admission and discharge dates were formatted in numeric values (Julian or SAS). We then compared this to the LOS variable in the NVH file. Table 11 shows the distribution of LOS in the two sources. The distributions have only moderate similarity. They had similar proportions of one-day stays, but the Fee Basis data had fewer stays of 2-9 days' length and more of 10 days or more.

Table 11. Length of Stay among FY2003 Inpatient Discharges in the INPT and PTF Non-VA Hospitalization Files

Length (days)	New Fee Basis Discharge File		PTF Non-VA Hospitalization	
	Frequency	Percent	Frequency	Percent
1	11,107	22.1	3,969	21.5
2	6,809	13.6	3,057	16.5
3	4,805	9.6	2,455	13.3
4-5	5,597	11.7	3,102	16.8
6-7	3,467	6.9	1,874	10.1
8-9	2,043	4.1	1,093	5.9
10+	16,140	32.1	2,943	15.9
TOTAL	49,968	100.0	18,493	100.0

Note: Percentages may not add to 100% due to rounding. FY2003 and FY2004 data were combined to determine the entire set of Fee Basis discharges occurring during FY2003.

We next attempted to match admission and discharge dates for particular stays. Results appear in Table 12. Merging attempts were done sequentially by method, starting from the top method listed. Ninety percent of stays appearing in both files matched by both admission and discharge dates and had identical lengths of stay. In most other cases, LOS differed by one or two days. Only 747 (4.5%) did not match by admission date or discharge date.

Table 12. Comparing Length of Stay in FY2003 INPT and PTF Non-VA Hospitalization Files[1]

Matching method	LOS equal	LOS differs by 1 day	LOS differs by 2 days	TOTAL
Admission and discharge dates	14,985	1	0	14,986
-- Admission date only	17	177	308	502
---- Discharge date only	32	212	222	466
------ Other	16	37	694	747
TOTAL	15,050	427	1,224	16,701

Key: LOS = length of stay

[1]Includes stays that appear in both files. FY2003 and FY2004 data were combined to determine the entire set of Fee Basis discharges occurring during FY2003.

Matching INPT and ANIP Records

The ANIP file contains ancillary inpatient services, such as laboratory tests, and physician payments for inpatient care. Payments for physicians employed directly by the hospital, such as anesthesiologists, will appear within the facility payments in the INPT file. Ancillary and physician payments accounted for $46.4 million in FY2003, roughly one-eighth of the total payments (DISAMT) of $401.9 million for INPT and ANIP records. These values represent payments during the fiscal year, some of which correspond to stays in prior years.

Each inpatient stay paid by VA should have at least one INPT record. We believe that nearly all stays lasting two days or more should have a matching ANIP record as well. Only stays involving no ancillaries and no outside physicians would have only a INPT record. Thus, we expect that nearly all ANIP records could be matched to INPT records. The facility and the physician may submit invoices to VA at different times, however, and so some stays, particularly those near the end of a fiscal year, may lack ANIP or INPT records in that year.

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To determine the correspondence between the two files, we attempted to merge them by patient ID (SCRSSN), facility ID (VENDID), and service dates. The service dates for the inpatient stay consisted of the first and last dates of the chain of invoices, as described above. The service date for the ANIP file is a single date (TREATDT). We considered an ANIP record to match an

Table 13. Matching Ancillary (ANIP) and Inpatient (INPT) Records, FY2003[1]

Status of ANIP Record	# Records	Percent of Records	Total Payments	Percent of Payments
Matching INPT record	237,493	84%	$46.4 million	80%
No matching INPT record	43,795	15%	$11.0 million	19%
Excluded: ANIP service date on boundary[2]	1,598	1%	$0.4 million	1%

[1] FY2003 and FY2004 data were combined to determine the entire set of Fee Basis discharges occurring during FY2003.
[2] Service date was the first or last day of FY2003

INPT record if the patient and facility IDs matched and if the ANIP service date fell within the service dates of the INPT record(s).

Results appear in Table 13. Eighty-four percent of FY2003 ANIP records could be matched to a FY2003 INPT record. Fifteen percent of ANIP records could not be matched to an INPT record. These records either contain errors in one or more of the matching variables or correspond to INPT records from an earlier fiscal year. One percent was excluded because the ANIP service date was either the first day or the last day of FY2003. In such cases, the inpatient stay likely began prior to FY2003 or ended after FY2003, making a match unlikely.

Notes and Recommendations

▪ To identify care at a particular location or of a particular type, search using all relevant variables. For example, place of service (PLSER), treatment code (TRETYPE), and purpose of visit (FPOV) can all be used to locate nursing home care.

- If the patient was transported to a VA hospital after stabilization, the record of the VA stay should appear in VA utilization databases. If it cannot be located in the PTF Main file or DSS NDE for inpatient care, search the other inpatient files: observation care, bedsection / treating specialty files, extended care, and end-of-FY census. If it still cannot be found, then the stay may have ended on the day the person stabilized.

- To create a single record for an inpatient stay, concatenate adjacent INPT records using patient ID (SCRSSN or SSN), vendor ID (VENDID), and treatment dates (TREATDTF, TREATDTO). VENDID is required because patients may be transferred directly from one facility to another.

- The total cost of inpatient stays includes the costs from INPT and ANIP records.

- Define length of stay (LOS) as *[max(1, max(stopdt)-min(startdt))]*. This yields very high concordance with LOS figures in the PTF NVH.

- Watch for a spike in LOS at 364/365—shows people probably not yet discharged (and possibly hanging over from previous year)

VI. Institutional Aspects of the Fee Basis System

Using the Fee Basis data for research requires a basic understanding of laws and regulations that govern it. This section describes two elements of the program: the range of services covered and the payment rules used to determine the amount that VA will pay (DISAMT). Additional information appears in federal statute (38 CFR 17.52).

Coverage

The Fee Basis program covers the full range of medical and dental care, with these exceptions:

- Elective and non-emergent surgery, except where VA facilities are not feasibly available.
- Care for dependent children, including newborns in situations where VA pays for the mother's obstetric care during the same stay
- Inpatient care beyond the time when a patient is stabilized and can be transferred to a VA facility, except where a VA facility is not feasibly available.
- Care provided in foreign countries other than the Phillipines.
- Inpatient care, regardless of patient's health status, if VA was not notified within 72 hours of admission. This rule applies even when the patient is incapable of making a call. (Veterans may submit unauthorized claims, however, and VA has legal authority to pay them under certain conditions. See 38 USC 1725 and 1728.)
- A claim for which the veteran had coverage by a "health plan," as defined in statute. Health plans include private health insurance, Medicare, Medicaid, and other forms of insurance that will pay for medical treatment arising from the patient's injury or illness (e.g., automobile insurance following a car accident). The generosity of the coverage is immaterial; if it covers any part of the provider's bill, then VA may not pay anything. If a patient has Medicare Part A coverage but not Part B, then VA may pay charges that would have been covered by Part B.[6]

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[6] The national Fee office notes: "This reference is specific to certain claims for Non-Service Connected emergency medical care under Title 38 USC 1725 which stemmed from Public Law 106-117, Section 111, Veterans Millennium Health Care and Benefits Act. The section of the Act expanded authority for VA to consider payment of certain emergency medical care claims for certain veterans. Among the several limitations to this benefit is that the veteran can have no other health care coverage, in whole or in part, for the episode of care claimed."

- Outpatient prescriptions beyond a 10-day supply. The prescription must be for a service-connected condition or must otherwise have specific approval.

Payment by VA requires timely filing of claims and supporting documentation. VA has established rules for timely filing of unauthorized and Millenium Bill ("Mill Bill") claims; see 29 CFR 17.120 and 38 CFR 17.1004. Four FPOV (Fee Purpose of Visit) codes can be used to identify payment for unauthorized claims.

Fee Card Eligibility

The Fee ID card enables veterans to obtain regular outpatient care outside VA. The card relieves the veteran of the need to obtain separate permission for each visit. Eligibility is based on service connection and other factors, as follows:

(1) Veterans with less than 50% service connection, for treatment of the service-connected disability;
(2) Veterans with 50% or greater service connection, for treatment of any condition;
(3) Veterans receiving aid and attendance (A&A) or housebound status (HB) payments, for treatment of any condition;
(4) Veterans enrolled in a Vocational Rehabilitation Program, for any treatment that is considered necessary to enable the veteran to enter, continue, or reenter training;
(5) Veterans of World War I, for treatment of any condition;
(6) When VA facilities are not feasibly accessible or medically available.

Exceptions may be made when VA will save money by doing so, or when it is medically contraindicated for the veteran to travel to the nearest VA facility.

Payment Rules

For inpatient facility charges (those recorded in the INPT file), VA will pay the lesser of (a) any contract payment negotiated with the provider, (b) the Medicare payment (from the CMS PRICER software) for hospitals that participate in Medicare, or (c) a national cost-to-charge ratio multiplied by the billed amount for charges that are "reasonable, usual, customary," and not in

excess of what the general public is charged, for hospitals that do not participate in Medicare. Payments in Alaska are greater.

For outpatient services (MED file) and for anesthesia, other physician charges, and ancillary services relating to inpatient stays (ANIP file), VA will pay the lesser of (a) the amount billed, (b) the amount calculated using the 75th percentile methodology,[7,8] (c) the usual and customary rate (if there were fewer than eight occurrences of the code in the previous fiscal year), or (d) the contract payment negotiated with the provider. Dental services are paid according to state-specific schedules.

For outpatient pharmacy charges (PHR file), VA will pay the Average Wholesale Price (AWP) listed in the annual *Drug Topic Red Book*, plus the Medicaid dispensing fee of the provider's state.[9] If medication was obtained on an emergency basis, then VA will reimburse the actual amount paid to the veteran.

Many classes of veterans are eligible for travel payments. VA will arrange for transportation for them or will reimburse expenses on the basis of vouchers submitted. Reimbursements appear in the Travel Expenses (TVL) file. There is a deductible of $3 per trip up to a limit of $18 per month. VA can waive the deductible in hardship cases.

If a claim is filed for an eligible episode of care, VA must pay the whole charge. VA will not pay only a deductible, copayment, or COB (coordination of benefits) amount. If eligible care

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[7] "Payment under the 75th percentile methodology is determined for each VA medical center by ranking all occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid" (38 CFR §17.56(c)).

[8] In Alaska, the 75th percentile methodology has been supplanted by special rules as of October, 2004. See *Federal Register* vol. 70 no. 23, pp. 5926-5927 (Feb. 4, 2005).

[9] If a branded medication is prescribed in a non-emergent situation, VA will reimburse only the cost of a generic equivalent, when one exists.

was already partly paid by the patient or his/her representative, then VA will reimburse for charges it was willing to pay. [10]

VA payment constitutes payment in full. Providers cannot bill both VA and another insurer for the same encounter. Providers are not required to accept VA payment in all cases. If the provider declines VA payment, it may be able to charge the patient a greater total amount.

The claim must be filed within 2 years of the service or within 2 years of notification of service connection for a condition treated in the non-VA facility, whichever is later.

Notes and Recommendations

- Some Fee Basis claims are rejected for untimeliness or lack of statutory authority. For these reasons, the program does not pay for 100% of care that was otherwise eligible.
- The TREATDT in the physician services (MED) file may be more than 2 years prior to start of the fiscal year in question. The same is true for the invoice end date (TREATDTO) in the outpatient ancillary (ANIP) and inpatient services (INPT) files: < 1.0% of records has TREATDTO more than 2 years prior to start of the fiscal year. These unusual invoices may reflect claims that were initially denied and then appealed, or they may simply reflect errors in data entry.

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[10] See Fee Handbook 1999, page 4-3.

VII. Summary of Notes and Recommendations

This chapter restates the notes recommendations presented earlier and adds several more. They are listed in bulleted format by topic.

Finding cases

- To identify care at a particular location or of a particular type, search using all relevant variables. For example, place of service (PLSER), treatment code (TRETYPE), and purpose of visit (FPOV) can all be used to locate nursing home care (INPT and ANIP files).

- Investigate whether variables give contradictory information on place of service or service type. There is no widely accepted standard for determining how much agreement across variables is sufficient.

- If the patient was transported to a VA hospital after stabilization, the record of the VA stay should appear in VA utilization databases. If it cannot be located in the PTF Main file or DSS NDE for inpatient care, search other inpatient files. If it still cannot be found, then the stay may have ended on the day the person stabilized.

- When developing search criteria, keep in mind that some variables have more than a few missing values.

- Missingness can vary substantially by year, by file, and by variable.

Creating discharge records from invoice records

- To create a single record for an inpatient stay, concatenate adjacent INPT records using patient ID (SCRSSN or SSN), vendor ID (VENDID), and treatment dates (TREATDTF, TREATDTO). VENDID is required because patients may be transferred directly from one facility to another.

- The total cost of inpatient stays includes the costs from INPT and ANIP records.

- Define length of stay (LOS) as *[max(1, max(stopdt)-min(startdt))]*. This yields very high concordance with LOS figures in the PTF NVH.

- Watch for a spike in LOS at 364/365—shows people probably not yet discharged (and possibly hanging over from previous year)

Costs and payments

- Watch for outlier values. One method for replacing an apparent outlier is to use the average value of payments for the same CPT in the same year, if possible to the same provider.

- VA will pay invoices as late as two years after the service was rendered. One must therefore look across three years of Fee Basis records to find all costs for a particular fiscal year. In practice, all invoices for most encounters are paid within six months. The average payment lag is 4-5 months – longer than in private sector.

- Total contract spending is in (former) CDR and is estimated in MPCR. Traditionally it has greatly exceeded the total value of Fee Basis care.

- Some Fee Basis claims are rejected for untimeliness, or lack of statutory authority. For these reasons, the program does not pay for 100% of care that was otherwise eligible.

Apparent data anomalies

- There may be multiple VENDIDs for a single stay. This could indicate a transfer between facilities or a physician bill for an inpatient stay. Note that some physicians use the same ID number as the hospital.

- There may be multiple STA3Ns for a single stay. This rare event most likely indicates a transfer.

- The TREATDT in the physician services (MED) file may be more than 2 years prior to start of the fiscal year in question. The same is true for the invoice end date (TREATDTO) in the outpatient ancillary (ANIP) and inpatient services (INPT) files. We found that < 1.0% of records has a TREATDTO date more than 2 years prior to start of the fiscal year. These unusual invoices may reflect claims that were initially denied and then appealed, or they may simply reflect errors in data entry.

Other notes

- A fiscal year represents all claims paid during the year. It does not represent all claims received, nor all claims incurred. As stated above, there is often a lag in claims and claims can be made up to two years after the service date.

- Be cautious about comparing Fee Basis costs and workload across fiscal years. Reporting has been uneven over time, and thus an apparent increase may simply reflect more accurate reporting. Because invoices may be submitted up to two years after services were rendered, year-to-year comparisons of workload should take place after two years have elapsed.

- The same concept (such as fiscal year, state, or county) may be represented by several variables, sometimes in differing formats.

VIII. Contacts for the Fee Basis program

The Fee Basis program has been managed by the VA Health Administration Center (HAC) in Denver, Colorado, since FY2003. Funding and authorization decisions remain at the local (station) level. Key informants include the following:

- Les Niemiec (leslie.niemiec2@med.va.gov), the National Fee Program Manager at HAC, for questions about program rules and management. The HAC help desk (hac.feeinq@med.va. gov) is another source.

- Judy Sine (judy.sine@va.gov) at the Austin Automation Center for questions about Fee Basis files

HAC maintains two web sites on the Fee Basis program. For an internet web site with general information and Frequently Asked Questions for veterans and providers, visit www.va.gov/hac/ hacmain.asp and click on the "Non-VA Care" tab at the top. A website on the VHA intranet offers detailed information for VA researchers, VISTA users, and managers. HERC will provide the URL to VA employees on request. The intranet site features Frequently Asked Questions for researchers/managers and minutes of the National Fee Call. It also features the VISTA Fee Basis User Manual. The manual is intended for people entering data into VISTA and will not be useful to most researchers.

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Appendix 1.   Processing of Fee Claims

The national Fee Basis program office provided the following description of Fee claims processing:

> Data regarding Fee authorizations and claims payment is transmitted from the local VistA Fee database to the Central Fee Production and Data Repository. Subsequent processing includes the transmission of Fee payment data to the Financial Management System and US Treasury. Payments to providers can be made via US Treasury Check (known as FV Vouchers), Electronic Funds Transfer or Purchase Card. Payment information is sent back to the local VistA database from Treasury/FMS via Central Fee. The Central Fee Repository serves as a data warehouse for a variety of Fee production reports. Frequency of reports production is based on the respective report. There are daily, monthly, quarterly, semi-annual and annual reports. In addition, there are reports in the VistA Fee software that are used to manage a local VAMC Fee business activity and provide resources for responses to other inquiries.

Appendix 2.1 Contents of FY2004 Inpatient (INPT) File

Physical Name: MDPPRD.MDP.SAS.FEN.FY04.INPT

                        Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	6		SCRAMBLED SSN	0
2	ZIP	Num	6		ZIP CODE	0
3	STA6A	Char	6			0
4	STA3N	Num	3	STA3NL.	PARENT STATION	0
5	HOMECNTY	Num	4	COUNTYL.	PATIENT COUNTY CODE	0
6	HOMSTATE	Num	2			0
7	DXLSF	Char	6		1ST DIAG CODE (NO DECIMAL)	55.3
8	DX2	Char	6		2ND DIAG CODE (NO DECIMAL)	57.5
9	DX3	Char	6		3RD DIAG CODE (NO DECIMAL)	59.7
10	DX4	Char	6		4TH DIAG CODE (NO DECIMAL)	62.8
11	DX5	Char	6		5TH DIAG CODE (NO DECIMAL)	66.6
12	SURG9CD1	Char	6		1ST SURG CODE (NO DECIMAL)	75.8
13	SURG9CD2	Char	6		2TH SURG CODE (NO DECIMAL)	83.5
14	SURG9CD3	Char	6		3RD SURG CODE (NO DECIMAL)	88.5
15	SURG9CD4	Char	6		4TH SURG CODE (NO DECIMAL)	92.8
16	SURG9CD5	Char	6		5TH SURG CODE (NO DECIMAL)	94.7
17	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
18	STANUM	Char	6			--
19	INVNUM	Char	9		INVOICE NUMBER	0
20	INVLNNUM	Char	2			--
21	SSNSUF	Char	1			99.9
22	PAYTYPE	Char	1	$PAYTFMT.		0
23	VEN13N	Char	30		VENDOR ID WITH SUFFIX	0.3
24	VENDID	Char	9			0.3
25	VENSUF	Char	4			62.2
26	VENSITEN	Char	1			--
27	AMOUNT	Num	8		PAYMENT AMOUNT	0
28	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0

Appendix 2.1 (cont'd)   Contents of FY2004 Inpatient (INPT) File

#	Variable	Type	Len	Format	Label	Percent Missing
29	PATTYPE	Char	2	$PATTFMT.	PATIENT TYPE CODE	0
30	TREATDTF	Char	8		TREATMENT DATE FROM	0
31	TREATDTO	Char	8		TREATMENT DATE TO	0
32	PROCDTE	Char	8		PROCESSING DATE	0
33	INVDATE	Char	8		DATE INVOICE RECEIVE	0
34	MDCAREID	Char	6		MEDICARE PROVIDER ID	100.0
35	STATE	Char	2			0.1
36	CNTY	Num	8			0.1
37	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0
38	SUSCODE	Char	2	$SUSFMT.	SUSPENSE CODE	62.9
39	CPT1	Char	5		CPT CODE	100.0
40	CLMDATE	Char	8		DATE RELEASED TO CALM	0
41	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0
42	PAMTCL	Num	8		AMOUNT CLAIMED	0
43	PAMT	Num	8		PRICER AMOUNT	61.9
44	PDRG	Char	4		PRICER DRG	0
45	VINVDATE	Char	8		VENDOR INVOICE DATE	0
46	RELNO	Char	4		RELEASE PREFIX NUMBER	0
47	JULDAY	Char	3		JULIAN DAY NUMBER	0
48	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0
49	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0.2
50	DISAMT	Num	8		FMS DISBURSED AMOUNT	0.3
51	INTAMT	Num	8		FMS INTEREST AMOUNT	0.3
52	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0.2
53	CHKDAT	Char	8		FMS CHECK DATE	0.2
54	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.7
55	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.7
56	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.7
57	OBNUM	Char	100		OBLIGATION NUMBER	0
58	DHCP	Char	30		DHCP INTERNAL CTL NO.	0
59	FMSTNO	Char	11		FMS TRANSACTION NO.	0
60	LINENO	Char	3		FMS TRANS LINE NUMBER	0
61	TRANSDAT	Char	8		FMS TRANSACTION DATE	0.2
62	FISYR	Char	4			--
63	BATCHNUM	Char	5			--

Appendix 2.2 Contents of FY2004 Inpatient Ancillary (ANIP) File

Physical Name   MDPPRD.MDP.SAS.FEN.FY04.INPT.ANCIL

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	6		SCRAMBLED SSN	0
2	ZIP	Num	6		ZIP CODE	0
3	STA6A	Char	6			0
4	STA3N	Num	3	STA3NL.	PARENT STATION	0
5	HOMECNTY	Num	4	COUNTYL.	PATIENT COUNTY CODE	0
6	HOMSTATE	Num	2			0
7	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
8	STANUM	Char	6			0
9	INVNUM	Char	9		INVOICE NUMBER	0
10	INVLNNUM	Char	2			0
11	SSNSUF	Char	1			100.0
12	PAYTYPE	Char	1	$PAYTFMT.		0
13	VEN13N	Char	30		VENDOR ID WITH SUFFIX	0.3
14	VENDID	Char	9			0.3
15	VENSUF	Char	4			70.3
16	VENSITEN	Char	1			0
17	AMOUNT	Num	8		PAYMENT AMOUNT	0
18	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0
19	PATTYPE	Char	2	$PATTFMT.	PATIENT TYPE CODE	0
20	TREATDTF	Char	8		TREATMENT DATE FROM	0
21	TREATDTO	Char	8		TREATMENT DATE TO	0
22	PROCDTE	Char	8		PROCESSING DATE	0
23	INVDATE	Char	8		DATE INVOICE RECEIVED	0
24	MDCAREID	Char	6		MEDICARE PROVIDER ID	100.0
25	STATE	Char	2			0
26	CNTY	Num	8			0
27	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0
28	SUSCODE	Char	2	$SUSFMT.	SUSPENSE CODE	13.6
29	CPT1	Char	5		CPT CODE	0

Appendix 2.2 (cont'd)   Contents of FY2004 Inpatient Ancillary (ANIP) File

#	Variable	Type	Len	Format	Label	Percent Missing
30	CLMDATE	Char	8		DATE RELEASED TO CALM	2.2
31	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	1.8
32	VINVDATE	Char	8		VENDOR INVOICE DATE	1.8
33	RELNO	Char	4		RELEASE PREFIX NUMBER	2.2
34	JULDAY	Char	3		JULIAN DAY NUMBER	100.0
35	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	100.0
36	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0
37	DISAMT	Num	8		FMS DISBURSED AMOUNT	0
38	INTAMT	Num	8		FMS INTEREST AMOUNT	0
39	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0
40	CHKDAT	Char	8		FMS CHECK DATE	0.4
41	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.5
42	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	97.3
43	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.5
44	OBNUM	Char	100		OBLIGATION NUMBER	0
45	FMSTNO	Char	11		FMS TRANSACTION NO.	2.2
46	LINENO	Char	3		FMS TRANS LINE NUMBER	2.2
47	TRANSDAT	Char	8		FMS TRANSACTION DATE	2.2
48	FISYR	Char	4			0
49	BATCHNUM	Char	5			0
50	PLSER	Char	2	$PLSFMT.	PLACE OF SERVICE	2.2
51	HCFATYPE	Char	2	$HCFFMT.	HCFA TYPE OF SERVICE	7.4
52	ADHCP	Char	30		DHCP INTERNAL CTL NO.	2.2

Appendix 2.3 Contents of FY2004 Outpatient (MED) File

Physical Name   MDPPRD.MDP.SAS.FEN.FY04.MED

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	6	SSN11.	SCRAMBLED SSN	0
2	STA6A	Char	6			0
3	STA3N	Num	3	STA3NL.	PARENT STATION	0
4	ZIP	Num	6		ZIP CODE	0
5	HOMECNTY	Num	5	COUNTYL.	PATIENT COUNTY CODE	0
6	HOMSTATE	Num	2			6.8
7	DXLSF	Char	6		1ST DIAG CODE (NO DECIMAL)	0
8	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
9	STANUM	Char	6			0
10	INVNUM	Char	9		INVOICE NUMBER	0
11	INVLNNUM	Char	2			0
12	SSNSUF	Char	1			100.0
13	PAYTYPE	Char	1	$PAYTFMT.		0
14	VEN13N	Char	30		VENDOR ID WITH SUFFIX	0
15	VENDID	Char	9			0
16	VENSUF	Char	4			0
17	VENSITEN	Char	1			0
18	AMOUNT	Num	8	8.2	PAYMENT AMOUNT	0
19	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0
20	PATTYPE	Char	2	$PATTFMT.	PATIENT TYPE CODE	0
21	TREATDT	Char	8		TREATMENT DATE(SASDATE)	0
22	PROCDTE	Char	8		PROCESSING DATE(SASDATE)	0
23	TRETYPE	Char	1	$TTYPFMT.	TYPE OF TREATMENT CODE	0
24	INVDATE	Char	8		DATE INVOICE RECEIVED (SASDATE)	0
25	STATE	Char	2			0
26	CNTY	Num	8			0
27	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0
28	CPT1	Char	5		CPT CODE	0

Appendix 2.3 (cont'd) Contents of FY2004 Outpatient (MED) File

#	Variable	Type	Len	Format	Label	Percent Missing
29	SUSCODE	Char	2	$SUSFMT.	SUSPENSE CODE	100.0
30	PLSER	Char	2	$PLSFMT.	PLACE OF SERVICE	0
31	HCFATYPE	Char	2	$HCFFMT.	HCFA TYPE OF SERVICE	4.9
32	VATYPE	Char	2			100.0
33	CLMDATE	Char	8		DATE RELEASED TO CALM (SASDATE)	1.5
34	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0
35	VINVDATE	Char	8		VENDOR INVOICE DATE	98.5
36	RELNO	Char	4		RELEASE PREFIX NUMBER	1.5
37	JULDAY	Char	3		JULIAN DAY NUMBER	1.5
38	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	1.5
39	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0.1
40	DISAMT	Num	8		FMS DISBURSED AMOUNT	0
41	INTAMT	Num	8		FMS INTEREST AMOUNT	0
42	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0.1
43	CHKDAT	Char	8		FMS CHECK DATE	0.3
44	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.7
45	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	98.2
46	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.7
47	OBNUM	Char	100		OBLIGATION NUMBER	0
48	DHCP	Char	30		DHCP INTERNAL CTL NO.	1.5
49	FMSTNO	Char	11		FMS TRANSACTION NO.	1.5
50	LINENO	Char	3		FMS TRANS LINE NUMBER	1.5
51	TRANSDAT	Char	8		FMS TRANSACTION DATE	1.6
52	FISYR	Char	4			0
53	BATCHNUM	Char	5			0

Appendix 2.4   Contents of FY2004 Pharmacy Payments (PHR) File

Physical Name   MDPPRD.MDP.SAS.FEN.FY04.PHR

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	STA6A	Char	6		ADMITTING STATION	0
2	STA3N	Num	3	STA3NL.	PARENT STATION	0
3	HOMECNTY	Num	4	COUNTYL.		0
4	HOMSTATE	Num	2			0
5	SCRSSN	Num	6		SCRAMBLED SSN	0
6	ZIP	Num	6		ZIP CODE	0
7	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
8	STANUM	Char	6			0
9	INVNUM	Char	9		INVOICE NUMBER	0
10	INVLNNUM	Char	2			0
11	SSNSUF	Char	1			100.0
12	PAYTYPE	Char	1	$PAYTFMT.		0
13	VEN13N	Char	30		VENDOR ID WITH SUFFIX	25.9
14	VENDID	Char	9			25.9
15	CHAINNUM	Char	4			26.0
16	VENSITEN	Char	15			99.9
17	AMOUNT	Num	8		PAYMENT AMOUNT	0
18	FILLDTE	Char	8		DATE PRESCRIPTION FILLED(SASDATE)	0
19	PROCDTE	Char	8		PROCESSING DATE(SASDATE)	0
20	PRESC	Char	8		PRESCRIPTION NUMBER	0
21	INVDATE	Char	8		DATE INVOICE RECEIVED(SASDATE)	0
22	STATE	Char	2			0
23	CNTY	Num	8			0
24	HOMEPSA	Num	8		PRIMARY SERVICE AREA	0
25	AMTCLMD	Num	8		PAYMENT AMOUNT CLAIMED	0
26	CLMDATE	Char	8		DATE RELEASED TO CALM(SASDATE)	0.3
27	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0
28	VINVDATE	Char	8		VENDOR INVOICE DATE	0
29	RELNO	Char	4		RELEASE PREFIX NUMBER	0.3

Appendix 2.4 (cont'd) Contents of FY2004 Pharmacy Payments (PHR) File

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
30	JULDAY	Char	3		JULIAN DAY NUMBER	0.3
31	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0.3
32	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0.3
33	DISAMT	Num	8		FMS DISBURSED AMOUNT	0
34	INTAMT	Num	8		FMS INTEREST AMOUNT	0
35	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0.3
36	CHKDAT	Char	8		FMS CHECK DATE	0.6
37	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.5
38	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.2
39	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.5
40	OBNUM	Char	100		OBLIGATION NUMBER	0
41	DHCP	Char	30		DHCP INTERNAL CTL NO.	0.3
42	FMSTNO	Char	11		FMS TRANSACTION NO.	0.3
43	LINENO	Char	3		FMS TRANS LINE NUMBER	0.3
44	TRANSDAT	Char	8		FMS TRANSACTION DATE	0.6
45	FY	Char	4			0
46	BATCHNUM	Char	5			0

Appendix 2.5   Contents of FY2004 Pharmacy Vendors (PHARVEN) File

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Physical Name                 MDPPRD.MDP.SAS.FEN.FY04.PHARVEN
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#	Variable	Type	Len	Format	Label	Percent Missing
1	STA3N	Num	4	STA3NL.	PARENT STATION	0
2	HOMECNTY	Num	4	COUNTYL.	PATIENT COUNTY CODE	0
3	HOMSTATE	Num	2			0
4	STA6A	Char	6			0
5	VZIP	Num	6		VENDOR ZIP CODE	0
6	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
7	VEN13N	Char	13		VENDOR ID WITH SUFFIX	0
8	VENDID	Char	9			0
9	VENSUF	Char	4			0
10	VENNAME	Char	30			0.1
11	PARTCODE	Char	2	$PARTFMT.	PARTICIPATION CODE	100
12	SPECCODE	Char	2	$SPECFMT.	SUSPENSE CODE	100
13	JANMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JANUARY	0
14	FEBMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR FEBRUARY	0
15	MARMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MARCH	0
16	APRMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR APRIL	0
17	MAYMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAY	0
18	JUNMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUNE	0
19	JULMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JULY	0
20	AUGMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR AUGUST	0
21	SEPMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR SEPTEMBER	0
22	OCTMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR OCTOBER	0
23	NOVMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR NOVEMBER	0
24	DECMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR DECEMBER	0

Appendix 2.6   Contents of FY2004 All Other Vendors (VEN) File

Physical Name   MDPPRD.MDP.SAS.FEN.FY04.VEN

#	Variable	Type	Len	Format	Label	Percent Missing
1	STA3N	Num	4	STA3NL.	PARENT STATION	0
2	HOMECNTY	Num	4	COUNTYL.	PATIENT COUNTY CODE	0
3	HOMSTATE	Num	2			0
4	STA6A	Char	6			0
5	VZIP	Num	6		VENDOR ZIP CODE	0
6	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
7	VEN13N	Char	13		VENDOR ID WITH SUFFIX	0
8	VENDID	Char	9			0
9	VENSUF	Char	4			0
10	VENNAME	Char	30			0
11	PARTCODE	Char	2	$PARTFMT.	PARTICIPATION CODE	100
12	SPECCODE	Char	2	$SPECFMT.	SUSPENSE CODE	100
13	JANMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JANUARY	0
14	FEBMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR FEBRUARY	0
15	MARMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MARCH	0
16	APRMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR APRIL	0
17	MAYMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAY	0
18	JUNMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUNE	0
19	JULMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JULY	0
20	AUGMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR AUGUST	0
21	SEPMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR SEPTEMBER	0
22	OCTMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR OCTOBER	0
23	NOVMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR NOVEMBER	0
24	DECMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR DECEMBER	0

Appendix 2.7 Contents of FY2004 Travel Payments (TVL) File

Physical Name   MDPPRD.MDP.SAS.FEN.FY04.TVL

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	6		SCRAMBLED SSN	0
2	STA6A	Char	6			0
3	STA3N	Num	3	STA3NL.	PARENT STATION	0
4	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
5	STANUM	Char	6			0
6	INVNUM	Char	9			0
7	INVLNNUM	Char	2			0
8	SSNSUF	Char	1			100
9	PAYTYPE	Char	1	$PAYTFMT.		0
10	VEN13N	Char	30			100
11	VENDID	Char	9			100
12	CHAINNUM	Char	4			100
13	VENSITEN	Char	15			100
14	TVLAMT	Num	8	8.2		0
15	TVLDTE	Char	8		TRAVEL DATE(SASDATE)	0
16	PROCDTE	Char	8		PROCESSING DATE(SASDATE)	0
17	CLMDATE	Char	8		DATE RELEASED TO CALM (SASDATE)	0
18	INTIND	Char	1	$INTFMT.	INTEREST INDICATOR	0
19	VINVDATE	Char	8		VENDOR INVOICE DATE	0
20	RELNO	Char	4		RELEASE PREFIX NUMBER	0
21	JULDAY	Char	3		JULIAN DAY NUMBER	0
22	PAYCAT	Char	1	$PAYCAT.	PAYMENT CATEGORY	0
23	ACTCODE	Char	1	$ACTCODE.	FMS ACTIVITY CODE	0
24	DISAMT	Num	8		FMS DISBURSED AMOUNT	0
25	INTAMT	Num	8		FMS INTEREST AMOUNT	0
26	EFTNO	Char	15		FMS CHECK/EFT NUMBER	0
27	CHKDAT	Char	8		FMS CHECK DATE	0.4
28	CANDAT	Char	8		FMS CHECK CANCEL DATE	99.5

Appendix 2.7 (cont'd)   Contents of FY2004 Travel Payments (TVL) File

#	Variable	Type	Len	Format	Label	Percent Missing
29	CANCODE	Char	1	$CANCODE.	FMS CHECK CANCEL CODE	99.5
30	CANRSN	Char	2	$CANRSN.	FMS CHK CANCEL REASON	99.5
31	OBNUM	Char	100		OBLIGATION NUMBER	0
32	DHCP	Char	30		DHCP INTERNAL CTL NO.	0
33	FMSTNO	Char	11		FMS TRANSACTION NO.	0
34	LINENO	Char	3		FMS TRANS LINE NUMBER	0
35	TRANSDAT	Char	8		FMS TRANSACTION DATE	0
36	FY	Char	4			0
37	BATCHNUM	Char	5			0

Appendix 2.8 Contents of FY2004 Fee Card (VET) File

Physical Name   MDPPRD.MDP.SAS.FEN.FY04.VET

Variables in Creation Order

#	Variable	Type	Len	Format	Label	Percent Missing
1	SCRSSN	Num	6	SSN11.	SCRAMBLED SSN	0
2	STA6A	Char	6			0
3	STA3N	Num	3	STA3NL.	PARENT STATION	0
4	ZIP	Num	4		ZIP CODE	0
5	HOMECNTY	Num	5	COUNTYL.	PATIENT COUNTY CODE	0
6	HOMSTATE	Num	2			0
7	STASUF	Char	3			100.0
8	TYPE	Char	1	$TYPEFMT.	RECORD TYPE CODE	0
9	SSNSUF	Char	1			100.0
10	SUFNAM	Char	10			97.7
11	VTADDR1	Char	35			0
12	VTADDR2	Char	35			93.4
13	VTADDR3	Char	35			99.6
14	VTCITY	Char	30			0
15	ISSUEDT	Char	8		ISSUE DATE	0
16	VALENDY	Char	8		END VALIDITY DATE	0
17	CNTY	Num	8			0
18	DOB	Char	8		DATE OF BIRTH	0
19	FPOV	Char	2	$POVFMT.	FEE PURPOSE OF VISIT CODE	0
20	TRETYPE	Char	1	$TTYPFMT.	TREATMENT CODE	0
21	XSEX	Char	1			0
22	POW	Char	1			0
23	DEATHDT	Char	8		DEATH DATE	0
24	WARCODE	Char	2	$WARFMT.		0
25	VTICN	Char	17			100.0
26	CCCODE	Char	1			0
27	CCADDR1	Char	35			100.0
28	CCADDR2	Char	35			100.0
29	CCCITY	Char	30			100.0

Appendix 2.8 (cont'd)   Contents of FY2004 Fee Card (VET) File

#	Variable	Type	Len	Format	Label	Percent Missing
30	CCST	Char	2			100.0
31	CCZIP	Char	9			100.0
32	STRTDTE	Char	8			0
33	ENDDTE	Char	8			0
34	CCCNTY	Char	3			0
35	AGECNTL	Char	2			95.5
36	LPAYTYP	Char	1	$LPAYFMT.	TYPE LAST PAYMENT	30.0
37	LASTPAY	Char	8		DATE LAST PAYMENT	0
38	DELCODE	Char	1		DELETE CODE	98.6
39	JANMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JAN	0
40	FEBMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR FEB	0
41	MARMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAR	0
42	APRMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR APR	0
43	MAYMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR MAY	0
44	JUNMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUN	0
45	JULMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR JUL	0
46	AUGMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR AUG	0
47	SEPMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR SEP	0
48	OCTMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR OCT	0
49	NOVMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR NOV	0
50	DECMOTR	Num	8	8.2	AMOUNT OF TREATMENT FOR DEC	0
51	SEX	Char	1			0

Appendix 3.   Formatted Values of Selected Variables in FY2004

FPOV: Fee Purpose of Visit

Value	Label	Value	Label
1	COMP AND PEN	33	CNH NSC DISABIL
2	OPT UNAUTH CLAIM	34	CNH ACTIVE DUTY
3	APP-MED BENEFIT	35	CNH HOSPICE & PALLIATIVE
4	VA INSURANCE	36	CNH RESPITE CARE
5	OPT FOR NSC	37	CONT READJUST
6	AA/HB BENEFITS	38	OPT 38 U.S.C. 1725
7	MISCELLANEOUS	39	MST
8	OPT WWI MEX BOR	40	CONTRACT HALFWAY HOUSE
9	OPT < 50% SC	41	HOME HEALTH NURS
10	OPT > OR =50% SC	42	HOME HEALTH
11	OBVIATE NEED	43	RESPITE CARE IN HOME/HOME HAS
12	CLASS I DENTAL	44	RESPITE CARE IN ADHC
13	CLASS II DENTAL	45	HHS (NON-NURSE PROF)
14	CLASS IIA DENTAL	46	CHIROPRACTIC CARE
15	CLASS IIB DENTAL	47	ADULT DAY HEALTH CARE (ADHC)
16	CLASS IIC DENTAL	48	OPT HOSPICE FEE
17	CLASS IIR DENTAL	49	OPT HOSPICE CONT
18	CLASS III DENTAL	50	RESPITE CARE OTHER
19	CLASS IV DENTAL	51	OPT DIAGNOSTIC
20	CLASS V DENTAL	52	SUPP OPT SERVICE
21	CLASS VI DENTAL	53	FEE OXYGEN
22	CON HOSP FOR SC	54	OPT INPATIENTS
23	UNAUTH CON HOSP	55	SUPP ALLERGY
24	CON HOSP EMER VA	56	OPT FOR OPTS
25	CON HOSP EMER FED	57	STATE ADHC (ADULT DAY HEALTH CARE)
26	CON HOSP WOMEN		
27	CON HOSP NSC	58	STATE DOM
28	CON HOSP FED HOS	59	STATE HOSPITAL
29	IPT HOSPICE FEE	60	STATE NH (NURSING HOME)
30	IPT HOSPICE CONT		
31	IPT 38 U.S.C. 1725		NOTE: These values vary by year.
32	CNH SC DIS 38 USC 1710		

Appendix 3 (cont'd).   Formatted Values of Selected Variables in FY2004

HCFFMT: HCFA Payment Type

Value	Label
[blank]	UNKNOWN
0	BLD/PACKED CELLS
1	MEDICAL CARE
2	SURGERY
3	CONSULTATION
4	DIAG XRAY
43	DIAG XRAY PROF C
5	DIAG LAB
53	DIAG LAB PROF CO
6	RADIATION THERAP
7	ANESTHESIA
8	ASSIST SURG
9	OTHER MED SER
A	USED DME
B	AMB SURG CENTER
H	HOSPICE
L	RENTAL SUPP HOME
M	ALT PAY MN DIAL
N	KIDNEY DONOR
V	PNEUMOCCAL VACC
Y	2ND OP ELEC SURG
Z	3RD OP ELEC SURG

PAYCAT: Payment Category

Value	Label
C	CONTRACT HOSPITAL
D	DENTAL
H	CONTRACT HALFWAY HOUSE
K	DIALYSIS
M	MEDICAL
N	COMMUNITY NURSING HOME
P	PHARMACY
R	REIMBURSEMENT
T	TRAVEL

TYPE: Vendor Type

1	MEDICAL VENDOR
3	FEE MEDICAL
4	PHARM VENDOR
5	PHARMACY
7	STATE HOME
9	INPATIENT
T	TRAVEL

TRETYPE: Treatment Code

0	[none]
1	SHORT-TERMT
2	HOME NURSING SER
3	ID CARD FEE
4	STATE HOME

Appendix 3 (cont'd).   Formatted Values of Selected Variables in FY2004

PLSER: Place of Service

Value	Label	Value	Label
1	UNASSIGNED	33	HOSPICE
2	UNASSIGNED	34	UNASSIGNED
3	UNASSIGNED	35	UNASSIGNED
4	UNASSIGNED	36	UNASSIGNED
5	UNASSIGNED	37	UNASSIGNED
6	UNASSIGNED	38	UNASSIGNED
7	UNASSIGNED	39	UNASSIGNED
8	UNASSIGNED	40	AMBULANCE LAND
9	UNASSIGNED	41	AMBUL AIR/WATER
10	UNASSIGNED	42	UNASSIGNED
11	UNASSIGNED	43	UNASSIGNED
12	OFFICE	44	UNASSIGNED
13	HOME	45	UNASSIGNED
14	UNASSIGNED	46	UNASSIGNED
15	UNASSIGNED	47	UNASSIGNED
16	UNASSIGNED	48	UNASSIGNED
17	UNASSIGNED	49	FED QL HTH CTR
18	UNASSIGNED	50	INP PSYCH FACIL
19	UNASSIGNED	51	PSY PART HOSPIT
20	UNASSIGNED	52	COMM MHC
21	INP HOSPITAL	53	INT CARE/MENT/R
22	OPT HOSPITAL	54	RESID SUB ABUSE
23	EMERG RM HOSP	55	PSYCHIATRIC RTC
24	AMB SURG CENTER	56	MASS IMMUN CTR
25	BIRTHING CENTER	57	COMP IPT REH FAC
26	UNASSIGNED	58	COMP OPT REH FAC
27	UNASSIGNED	59	RENAL TREATMENT FAC
28	UNASSIGNED	60	ST/LOC PUB HTH CLC
29	UNASSIGNED	61	RURAL HTH CLINIC
30	SKILL NUR FACIL	62	INDEPENDENT LAB
31	NURSING FACIL	63	OTHER UNLIST FAC
32	CUSTOD CARE FAC		